

This form may be completed online, printed and mailed to the address listed below.

NURSE AIDE TERMINATION FORM

FACILITY _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER OR REGISTRY NUMBER _____

INDIVIDUAL'S NAME _____
(Last) (First) (Middle)

DATE TERMINATED _____

Please return this form to:

**Nurse Aide Registry
Credentialing Division
PO Box 94986
Lincoln, NE 68509-4986**

Rev 07-04

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